

CALIFORNIA'S HEALTH

WILTON L. HALVERSON, M.D.
DIRECTOR OF PUBLIC HEALTH

STATE DEPARTMENT OF PUBLIC HEALTH
ESTABLISHED APRIL 15, 1870

PUBLISHED SEMI-MONTHLY

ENTERED AS SECOND-CLASS MATTER FEB. 21, 1922, AT THE POST OFFICE AT SACRAMENTO, CALIFORNIA, UNDER THE ACT OF AUG. 24, 1912. ACCEPTANCE FOR MAILING AT THE SPECIAL RATE OF POSTAGE PROVIDED FOR IN SECTION 1103, ACT OF OCT. 3, 1917

SACRAMENTO (14), 621 J STREET, 2-4711

SAN FRANCISCO (2), 660 PHELAN BLDG., 760 MARKET ST., UN 8700

LOS ANGELES (12), STATE OFFICE BLDG., 217 W. FIRST ST., MA 1871

VOLUME 4, NUMBER 14

JANUARY 31, 1947

ANN WILSON HAYNES, Editor
JEROME GROSSMAN, Assistant

GOVERNOR WARREN ON HEALTH LEGISLATION

Governor Earl Warren outlined his legislative program on health in a press conference on December 27, 1946. The following is a summary of his statement as released to the press.

HEALTH IS FUNDAMENTAL

The most fundamental of all problems in our State is the health of our people. I propose to be as intensely interested in that subject in this and future sessions of the Legislature as I have been in the past. California is gifted almost beyond comparison insofar as opportunities for health are concerned, but we cannot continue to neglect some of the things that are necessary to supplement our natural advantages.

With the growth of our population many health problems have been aggravated to the extent that we are now in a worse situation than some other parts of the country.

17,000 HOSPITAL BEDS NEEDED

For instance, in California today we are short about 7,000 hospital beds, and about one-third of the beds we do have in our hospitals are either substandard or obsolete and should be entirely replaced. All told, we need about 17,000 hospital beds at the present moment. Of course, when I speak of hospital beds, I mean not just the beds themselves, but facilities for taking care of the patients as well.

California is growing at the rate of 27,000 persons per month. This total is made up of 20,000 persons coming into the State, and 7,000 births in excess of deaths. According to the best estimates of experts in the field, we should have four and a half hospital beds for every thousand people. Therefore, we should be building about 150 new hospital beds each month in addition to the 17,000 I have already mentioned.

That's a long, hard pull and we can't do it all at once. But we can do something substantial to help.

STATE SHOULD ASSIST IN HOSPITAL CONSTRUCTION

The Federal Government recently made an appropriation for hospital construction throughout the nation, which calls for matching appropriations by local communities. California, under this program, is entitled to approximately \$2,000,000 per year for the lifetime of the federal program. Under the act, the Federal Government contributes one dollar to the local community's two dollars.

It is my opinion that the State should help the communities in this program and share equally with them in the cost. In other words, I believe the cost should be divided equally among the three: The Federal Government should pay \$2,000,000, the State should pay \$2,000,000 and the local community should pay \$2,000,000.

FEDERAL APPROPRIATION UNREASONABLY LOW

If the Federal Government will increase its allocations to California, I will gladly recommend that the State appropriate more money, too. I am of the opinion that the allocations by the Federal Government are unreasonably low for California, and that it will take much more money to do the job which is needed.

Many of our rural areas have substandard hospital facilities. Fortunately, we have an agency through which we can work in the development of these hospital programs.

In 1945 we provided for the establishment of hospital districts in the State, and in the 15 months that the act providing for these districts has been in effect, 15 such districts have been formed. These new districts include Sonoma Valley, Paso Robles, Lompoc, Dinuba,

Corning, San Andreas, Coalinga, Hemet Valley, Petaluma, Patterson, Del Norte County, Inyo County, Marin County, Sierra Valley, and the Sequoia District of San Mateo County.

Still other such districts are in the process of formation. The extent to which our people in all parts of California have taken advantage of this statute shows the need for more hospitals, and greater activity will be in order whenever we are in a position to help the individual localities.

NO ONE SHOULD BE MORE THAN ONE HOUR DISTANT FROM A HOSPITAL

It should be our ambition and we should work diligently to see that no one in California is more than one hour distant from a hospital. That can be accomplished, and I believe it is the best method of making an approach to the problem.

COUNTY HEALTH SERVICES NEED DEVELOPMENT

Also, we want to step up very materially the health services in the various counties, because our health record in that respect is not good.

Twenty-six counties have no full-time health officer. Some counties go no further than to just satisfy the formalities of a health service without any real attempt to serve the people. Over half of the counties with full-time health officers provide only a minimum of service.

Thirty-six counties are without local public health laboratories. Five counties have no provision whatsoever for public health nursing service.

Fifty-three counties are without trained leadership in health education. These figures can add up only to a lack of health protection for a large percentage of the people of California.

DISEASES CONTINUE TO TAKE TOLL

As long as we have deaths from such preventable diseases as diphtheria, we know that many children are going without protection.

As long as there are outbreaks of typhoid, we know that the well-being of entire communities is in danger.

As long as there are outbreaks of dysentery in camps for children, we know that there is a lack of sanitation in some recreational areas.

All of these are occurring in California and are preventable, and we must do something to stop them.

STATE SHOULD CONTRIBUTE TO COUNTY PROGRAMS

First of all, we must have an adequate health service in every part of the State, and in order to stimulate such health service I will propose to the Legislature that the State pay a basic amount annually to every county that will establish and maintain a full-time health service for its people under standards that

will be established by the State Department of Public Health.

I am satisfied that if that is done, we can improve the health standards of our State generally, and go a long way toward eliminating communicable and contagious diseases.

TUBERCULOSIS ONE OF GREATEST SCOURGES

One of the greatest scourges in this State is still tuberculosis. We are losing about 4,000 people a year in California from this disease, and what is particularly alarming is the fact that at least one-fifth of these cases are unknown to the health agencies of the State until death has occurred.

This means that during all of the long period of illness, these victims have been a source of infection to those who immediately surround them, as well as to those members of the public with whom they have come in contact.

It is estimated that at present there are at least 20,000 ambulatory cases of tuberculosis in the State, unknown perhaps even to the patients themselves. Needless to say, these constitute a health threat to every person with whom they come in contact.

STATE SUBSIDY FOR TUBERCULOSIS TREATMENT MUST BE INCREASED

Some of our counties have no adequate hospital facilities for tuberculous patients, and many are substandard. We tried to remedy that situation to some extent two years ago by increasing the State subsidy from \$2 per week to \$7 per week per patient, but the cost of hospitalization has increased so much in recent years that this subsidy did not prove as effective as it might otherwise have been.

I am of the opinion that the State should make a very determined effort to eliminate tuberculosis from the life of our people, and in order to accomplish that result I propose that the State increase its subsidy for the care of the tuberculous on a basis of \$2.50 per day per patient for the first hundred patients in any county, approximately \$1.75 to \$2 per day for the next hundred patients, and \$1.25 per day for all patients over two hundred. Obviously, that will give smaller counties a greater percentage of help than the larger counties, but it is important that we have adequate care for tuberculous patients not only in our big communities but in our small ones as well.

This program may also be fitted in with the development of the hospital program.

We made a survey of all patients in our state hospitals a year or two ago, and found a shocking number with tuberculosis, in many instances unknown cases which were not being treated. You will find the same situation exists in almost every walk of life.

ADDITIONAL MENTAL HOSPITALS REQUIRED

In addition, we have the problem of our mental hospitals. We have been working diligently to improve their standards by relieving overcrowding, by stepping up the services rendered, and by providing clinical service for those who are suffering from ailments that may eventually take them to mental hospitals unless they are cured.

We are going to continue that program and raise our standard of medical and nursing service through increased numbers of doctors, nurses, and attendants until we compare favorably with the best public hospitals of that character in the country.

The Legislature has already provided for the establishment of a new mental clinic in Los Angeles comparable to the Langley Porter Clinic in San Francisco. We have made a start on it, and I hope that it will produce good results.

We have mentally ill persons in other parts of the State besides Los Angeles and San Francisco, however, and the establishment of clinics in strategic parts of the State is vital at this time. Therefore I will renew my request to the Legislature to establish clinics at Sacramento, Fresno, San Diego, and a second clinic in Los Angeles.

CLINICAL TREATMENT BENEFICIAL TO PATIENT AND TO STATE

We ought to move forward on that program, and treat people before it becomes necessary for them to go to a state hospital. With clinics, we can release patients from state hospitals sooner than otherwise, under supervision and proper care which are not now available.

In my opinion these clinics, in addition to other values, will save dollars and cents for the State, by preventing people from going to the hospital and by permitting their earlier release once they are there.

In a field of this kind, in which the State takes possession of the lives of sick people and confines them against their will when they have done no wrong but are merely ill, it has a very definite responsibility to give them the best possible care.

THE NEED FOR A GENERAL HEALTH INSURANCE PLAN

Then, of course, we get to the question of the general health of our people, and of making adequate medical care available to them all.

That problem is becoming more aggravated as time passes by, because the cost of medical care and hospitalization is increasing daily. I read in the press just a few days ago that hospitalization in California is more expensive than in any other state. It averages \$12.84 per day, which is beyond the reach of the work-

ing people of our State. When we add this to doctors' bills and other expenses of illness, it drives us to a realization of the fact that we must have a system of prepaid medical care based upon the principle of insurance which, by spreading the cost over a broad base, will enable every working man and woman in the State to provide adequate care for his or her family.

I am sure that there are few people who will disagree with the need for such a program, but many people disagree with the proposals that have heretofore been made to accomplish the result.

If we are to have the public interest at heart it behooves all of us to put selfishness behind us and to strive for means of solving this problem which is perhaps the most basic problem in the lives of all our people.

PREPAID MEDICAL ASSISTANCE PROGRAM REQUIRED

There will be introduced during the coming session of the Legislature a bill for prepaid medical assistance. I cannot state the terms of the bill at the present time, as I am waiting for a report of the Senate committee which is studying the question. The report of this committee will, I hope, be available soon.

NO ADEQUATE PRIVATE SYSTEM AVAILABLE

There is no adequate system of private health insurance which will enable the people to protect their families, so we must strive religiously to get something done. I am hopeful that the people who in the past have opposed such a system will instead of blindly fighting it, open their minds and try to help find a solution to the problem if they do not agree with the plan proposed.

W. P. SHEPARD ESTABLISHES TEMPORARY OFFICE IN NEW YORK

Dr. William P. Shepard, third vice president in charge of welfare activities in the Metropolitan Life Insurance Company, Pacific Coast head office, and recently elected president of the National Tuberculosis Association, has temporarily transferred his activities from California to New York City.

During his stay in the East, Dr. Shepherd will devote much of his time to activities of the American Public Health Association and the N. T. A.

In Dr. Shepard's absence, Dr. Anthony J. Lanza, Associate Medical Director, will spend a portion of his time at the M.L.I.'s San Francisco office, not only looking after welfare activities in general, but also providing special industrial hygiene activities to important Pacific Coast groups who have not before been served in this way.

C. G. GILLESPIE RETIRES AFTER 28 YEARS IN STATE SERVICE

C. G. Gillespie, who more than any other person is responsible for the development in California of the modern public health program in sanitary engineering, retired from state service in January.

In recognition of his ability, Mr. Gillespie recently was appointed special consultant to the Sanitation study Section of the National Institute of Health which makes recommendations to the National Advisory Health Council on grants for research in the field of environment sanitation.

Mr. Gillespie was appointed chief of the Bureau of Sanitary Engineering, State Department of Public Health, at the time of the organization of the Bureau, August 8, 1915, and served continuously in this capacity until his retirement, except for three years, 1920-22, when he was employed as resident engineer of the Sacramento water filtration plant. This was the first modern water treatment plant on the Pacific Coast and was developed following a study of the sewage pollution of the Sacramento River made by Mr. Gillespie prior to his employment by the State.

Possessed of a passion for anonymity, which he believed should be an attribute of every good worker in public service, Mr. Gillespie has consistently remained in the background. It is characteristic of the strength of his leadership that the program which he directed depended upon education to effect a gradual raising of standards to reach long range goals, some of which have been but recently achieved.

MILESTONES IN SANITARY ENGINEERING

On February 1, 1946, the Superior Court ordered the City of Los Angeles and satellite cities to stop pollution of the shores and waters of Santa Monica Bay with sewage. More than \$21,000,000 will be required to satisfy the judgment. The suit by the State was based on evidence collected by the Bureau of Sanitary Engineering in a study started in 1941.

The State Board of Public Health on March 11, 1946, ruled that no new permits will be issued for the disposal of raw sewage and industrial wastes into California streams, bays and ocean waters and that, effective January 1, 1947, all outstanding permits for this practice are revoked. This action, which culminates a long program of education, also marks the beginning of a new program to reclaim the purity of California waters.

In 1946, the Legislature in special session, appropriated \$600,000 for the control of disease bearing mosquitoes and for research in the control of mosquito-borne diseases, a further development in the mosquito control program conducted for many years.

Outstanding war service was given by the State in assisting military establishments with problems of water supplies and sewage disposal; in working out with local authorities definite programs for safeguarding public water supplies from enemy action and sabotage; and in preventing contamination of water supplies by cross connections at a time when shortage of materials and labor and heavy consumer use made this problem a critical one.

During the 21 years which have elapsed since its establishment, the Bureau of Sanitary Engineering through prompt action has effectively protected the people of California from sanitary hazards resulting from such catastrophes as the Santa Barbara and Long Beach earthquakes, the St. Francis dam disaster, the Port Chicago explosion, and recurrent floods in the great river valleys.

Other achievements include: Chlorination of all public water supplies subject to contamination and the first survey of garbage disposal practice to be made on the Pacific Coast, in 1934, which resulted in marked improvements.

THREE EXAMINATIONS SCHEDULED

Examinations for *Social Welfare Agent, Senior Public Health Analyst, and Senior Sanitary Engineer* have been announced by the State Personnel Board.

Final dates for filing applications and examination dates are given below. Further information may be obtained from the State Personnel Board, 1015 L Street, Sacramento.

Examination	Last date for filing applications	Examination date
Social Welfare Agent	Feb. 3, 1947	Feb. 21, 1947
Senior Public Health Analyst	Feb. 6, 1947	Feb. 27, 1947
Senior Sanitary Engineer	Feb. 11, 1947	March 4, 1947

CORRECTION

California is to receive \$1,958,000 a year over a five-year period for hospital construction under the Federal Hospital Survey and Construction Act.

Due to a typographical error, this figure was erroneously reported at \$958,000 in the December 31, 1946, issue of *California's Health*.

INSTITUTE FOR SANITARIANS PLANNED

An in-service training institute for sanitarians will be held by the Southern California section of the National Association of Sanitarians February 27th and 28th in Los Angeles.

Rodents and rodent control, food sanitation, industrial hygiene, and sanitization of glasses and utensils will be discussed.

REVIEW OF LEAGUE BOARD ACTIONS RELATING TO PUBLIC HEALTH*

RICHARD GRAVES, Executive Secretary, League of California Cities

I would like to talk to you for a while about public health from the standpoint of one who is deeply interested in it as a citizen and as a student of government and public administration.

My subject is, "Review of League Board Actions Relating to Public Health." That is a good way to keep a man quiet because, with one notable exception, there have not been any recent League Board actions relating to public health. The notable exception is the \$90,000,000 State Appropriation Bill enacted at the last special session of the Legislature.

SEWAGE DISPOSAL BILL

Insofar as the cities are concerned, the \$90,000,000 bill was a sewage disposal bill. It was by the voluntary action of your own state league, rather than by any requirement of the Legislature, that the language of the act requires a city to spend the money it receives for sewage treatment and disposal and for no other purpose, unless the State Department of Finance, after consultation with the State Department of Public Health, shall certify that the existing treatment and disposal facilities of the city are adequate or unless alternative financial provision has already been made to provide for an adequate system.

If we have done nothing else for public health, we have at least made possible the first long step in eliminating water pollution in our State and in the direction of providing adequate sewage treatment and disposal facilities.

I don't believe that \$90,000,000 appropriation finishes the job; I am concerned about the fact that many of the smaller cities and a great many rural unincorporated communities, even with this state assistance, do not have the financial capacity to provide adequate sewage treatment and disposal. In many of these areas, the cost of the facility required is out of scale to the size of the community and its taxable wealth. Now that the major principle of state participation has been established, I would suggest thoughtful consideration of this difficult aspect of the problem.

This is the most important thing the league has done which directly affects you. I would, therefore, like to talk to you about the actions which the league directors should take that would affect the public health. I would like to talk to you about the kinds of ideas, sug-

gestions and recommendations which should come to the league from you, asking us to do something fundamental about public health services in our State.

AN ADEQUATE STATE-WIDE PUBLIC HEALTH PROGRAM

First I would like to ask you a question I cannot answer: in terms of services, what should be the content of an adequate public health program in California? I am concerned about the fact that we are still operating our State with a governmental plan which was inadequate to serve the needs of six and one-half million people in 1940 and which is still more inadequate to serve the needs of the more than nine million people who now reside in our State. There are not even any plans for the twelve or fifteen or twenty million people who one day will live here.

Every sewage treatment plant still on the architect's drawing board is already inadequate to serve the needs of the community for which it is designed. We seem to be unable or unwilling to make adequate provision for the future. We live by the philosophy that whatever will get us by today is enough and the future must somehow take care of itself. That philosophy is not good enough. What we should have now in the way of a public health program, activities, services, I don't know, but I do know we are not bold enough in our thinking and planning about what ought to be in the public health program. Without regard to political limitations, you people who know public health must be free to say what you think and what you know about the public health requirements of our State. If you don't speak up, who can or will?

We need a different kind of public health program in a California with 9,000,000 people than we had before the war, if for no other reason than because these new elements of our population are weighted heavily against the public health. This is obvious and requires no elaboration.

We need not only an augmentation of established public health services, but surely we need some new services to maintain and raise the level of the public health of all our people. You who are the leaders in public health must propose and pretty largely determine what kind of a public health program is necessary. Certainly it will be controversial, argumentative, difficult to secure, politically inexpedient, but one day

* Presented before the Health Officers Department of the League of California Cities, September 13, 1946, San Diego.

you will get it if you are willing to work for it. If you will do that, I would like to enlist for the duration to get that kind of a public health program in our State.

Let us consider now not content of a public health program but rather who should do the job. If we had before us a list of all the kinds of services which should be provided for the benefit of the public health, it would be perfectly evident that a great many of them should be provided by the larger units or the higher levels of government. Public health is not a local or a municipal affair; it is basically a matter of state-wide concern. I believe in the principle of home rule, in the principle of keeping government as close to the people as we can. I don't believe in keeping government close to the people in a matter of state-wide concern if the result of local administration is to deprive the people of the services needed or of the capacity of government to render the service. I believe it is true that all the people everywhere require and are entitled to basic public health services, not only for their own sake, but for the protection of other people, and I do not believe that whether they get this service or not should depend upon the whims of five times 57 boards of supervisors, most of whom have already demonstrated they have very little interest in public health.

As a general proposition, I would advance the idea that while it would be desirable to have local administration of at least the basic public health program wherever local agencies are large enough to serve as effective areas of administration, it is not desirable to permit a situation to continue where local areas determine whether or not the people have the benefit of the basic public health program. If the local agencies cannot or will not provide such services, then certainly they must be provided in some other way.

I have been told by public health authorities that no governmental unit having less than 50,000 people can support a minimum adequate public health program. It is evident from this that a very great many counties, including the cities within them, are not large enough to support a public health program, and combinations of counties into districts, therefore, becomes an obvious necessity.

It is a tragedy that one of the reasons why it is so difficult to make an objective determination about who should do a particular job is because of the vested job interest of some of the people who are already engaged in the work. As the executive secretary of an organization, I can tell you in all honesty that a great deal of progress is retarded in this country by executive secretaries of organizations who are primarily concerned about their own jobs. Because they are in key positions, they manage to keep away from their boards of directors many of the things they ought to know and

to give them only a slanted or perverted notion of the facts about a particular proposal. Somehow you who are so directly responsible for the public health must rise above the level of that kind of thinking. If it is right that your job should be abolished, lend a hand, because if you have the capacity you will end up doing the job for the level of government which ought to be doing it. If you don't have the capacity, you ought not to be doing the job anyway.

MILK INSPECTION

It is my intention to ask the board of directors of the league for authority to propose amendments to all bills relating to milk inspection, such amendments being designed to take away from the Department of Agriculture all responsibility for milk inspection and to transfer that responsibility to the State Department of Public Health. This is not intended as any lack of confidence in the personnel of the State Department of Agriculture; what distresses me is that a public health function should be administered by a department which was organized and which necessarily thinks in terms of what will benefit agriculture.

Personally I do not believe we ought to have local milk inspection services, but I am equally determined that the inspection service we do have, the whole conception and administration of it, should be in public health. You may be very sure that if arbitrary and excessive regulations are imposed upon the producer or distributor, the Legislature would promptly rectify the situation.

I make this point because it illustrates what I am trying to say about job interest affecting decisions about who should perform a particular function. Some of the local agencies have been reluctant to give up milk inspection because of the jobs of the local milk inspectors and their concern about what would happen to these people. Doubtless one of the considerations which would be raised, if we propose to transfer milk inspection from agriculture to public health, would be the jobs of the people in agriculture, although under the State Civil Service System they would doubtless be transferred to public health.

The controlling consideration should be the interests of the people in pure milk and how best to provide the milk inspection service necessary to protect the public health with a minimum of expense and with a minimum of interference with the production and distribution of milk.

PRACTICAL PUBLIC HEALTH ADMINISTRATION

We must provide a practical working basis for public health administration. There are only a few cities which have the wealth, the size, or the desire to develop and maintain a municipal health program. Except for these

few cities, I am persuaded that what we need in this State is a 100 percent health district or health area system, covering the State from one end to the other, where every district without regard to its financial resources has the basic minimum essentials of a public health program. If the wealthier areas want a more elaborate program, let them have it and let them pay for it.

I do not believe, however, that the State of California must require and make provision for a basic minimum health program everywhere in California, and this can be done only if the areas for public health administration make some kind of sense economically and administratively. Certainly that is not the situation which prevails today. So, if I had my way, I would not find among the public health officials any great number who were working for the cities. But let me say also that I cannot accept the idea of abdicating the public health function to the county boards of supervisors who, with very few exceptions, have been unwilling to accept responsibility for decent public health service.

Let me add that in this district idea I think we should elaborate and refine the arrangement whereby the existing local agencies of government served by the health district are directly represented on the governing body of the health district by persons officially representing the existing governmental jurisdictions. We have too many districts with boards of directors deriving their authority directly from the people, with the result that we increase friction among these independent jurisdictions. It is a better system to have the cities and counties designate their official representatives to act administratively in the performance of the district function.

COMPETENT PERSONNEL

The third concept I want to suggest has to do with personnel. I was impressed when I heard that there are jobs available in public health which cannot be filled. I agree that this is largely because such jobs never carried the compensation which the performance of such a professional or technical job should command and most assuredly do not carry such compensation under present circumstances. But there is another reason too. We have never had adequate facilities in our State for training people for public health service.

While I agree that it is difficult to get good people to take this training when they are paid at the level of senior stenographers, it is also true that we have failed to provide the other bases upon which to offer a qualified person an attractive job.

We need whatever it will take to bring into public health service men and women of the highest level of

ability. That will take more adequate compensation; it will require better facilities for training and the universal requirement of training as a condition of employment. Finally, and as important as compensation, is the requirement that to the job of public health service be given public recognition of the importance of the task, of an opportunity to get a good job done. The public health job must be made important and effective. Nothing will drive able people out of a field quicker than lack of recognition and frustration. You know as well as I that men persist in activities when they could improve themselves financially by leaving, but they stay because their hearts are in the thing they are doing.

With further reference to the question of relations between the State and local governments in public health, it should also be possible for the State to provide certain services in connection with the training and recruitment of personnel. Incidentally, if state financial aid is to come into local public health work, it would undoubtedly be desirable for the State to establish personnel standards as well as requirements relating to types of service and standards of performance.

I have been impressed by the fact that in the related field of public welfare administration there was a great outcry when the Federal Government required the State to impose upon the counties a merit system for the recruitment of county welfare personnel, because the counties were spending large sums of state and federal money. Unquestionably this requirement very materially improved the quality of county welfare personnel. The most extraordinary thing about it is that today most of the county supervisors will tell you in all honesty that the requirement forced better personnel standards upon them and they have learned to like it. Strangely enough, they like it in public welfare administration but do not appear to recognize its value when applied to other activities.

FINANCING THE PROGRAM

The last phase of this discussion should appropriately be concerned with who is going to pay for this kind of public health service. Personally I do not believe that the Federal Government is going to continue indefinitely its federal aid policies. For that matter, I am beginning to question their wisdom or rather their value, so far as California is concerned. Admittedly the strong should help the weak, but the weak states gave us a pretty bad time in that federal hospital bill. We must agree also that there is an obligation and it is desirable for the Federal Government to use federal funds to secure for the people of the so-called backward states some minimum standards of

health service. However, that kind of a federal policy in such a state as California may well retard, rather than stimulate, more adequate development of public health services. Let us look a little more critically at proposals for federal aid and measure them more carefully against the comparative value of independent state action.

Speaking for myself, may I say that the State of California should participate very substantially in financing the basic public health program. However, if this is to be accomplished, we must at the same time work out a sensible administrative program for local public health administration and a set of relationships between the State and these local health units. If we are to go before the Legislature in 1947 with any proposal affecting public health in so important a way, we should make every effort to present to the Legislature a proposition that makes sense instead of being afraid of selfish or short-sighted opposition. It seems to me quite probable that if we do give the Legislature a proposal that makes administrative sense, they would be willing to help finance a public health program for our State.

I don't know where we would go to get the money. Recently one of the mayors was talking about possible sources of revenue and suggested a cigaret tax. A state cigaret tax, with all the revenue appropriated for public health service, might be a good idea and might appeal to the Legislature.

That is just about all I wanted to say. The two fields which interest me most and about which we have done the least to meet the requirements of the people are public health and recreation. You who must carry responsibility for leadership in public health have a serious obligation to all the people, and I urge upon you that you must be guided only by considerations of the public welfare as you propose the means by which we are to meet the public health requirements of our State.

FOUR SERVICES INCLUDED IN NEW DISEASE CONTROL BUREAU

Four bureaus of the Division of Preventive Medical Services of the State Department of Public Health have been brought together as a single administrative unit to be known as the Bureau of Disease Control.

The formerly separate bureaus of Acute Communicable Disease, Chronic Diseases, Tuberculosis, and Venereal Diseases will be part of the new bureau, each now being known as "Services."

There will be no change in existing personnel except in title. Operating programs and general policy will continue without change. One of the chiefs of the four services will be designated chief of the new bureau.

MORBIDITY REPORT—DECEMBER, 1946 CIVILIAN CASES

Reportable diseases	Week ending				Total cases	5-yr. median	Total cases
	12-7	12-14	12-21	12-28	Dec.	Dec.	Jan. Dec. inc.
Amebiasis (amoebic dysentery).....	1	4	4	3	12		188
Anthrax.....							
Botulism.....							
Chancroid.....	15	11	15	19	60		586
Chickenpox (varicella).....	752	1,007	729	607	2,995	3,015	26,574
Cholera, asiatic.....							
Coccidioid granuloma.....				2	2		41
Conjunctivitis—acute infectious of the newborn (Ophthalmia Neonatorum).....	2	1		2	5		84
Dengue.....							
Diarrhea of the newborn.....	8	1	18	1	28		184
Diphtheria.....	28	20	21	24	93	132	1,182
Dysentery, bacillary.....	3	4	10	8	25		385
Encephalitis, infectious.....	1	2	1	3	7		186
Epilepsy.....	26	27	17	31	101		1,489
Food poisoning.....	2	5	6	4	17		427
German measles (rubella).....	44	34	31	21	130		12,084
Glanders.....							
Gonococcus infection.....	458	605	533	598	2,194	1,485	33,366
Granuloma inguinale.....	1	2	1				42
Influenza, epidemic.....	15	13	9	14	51	358	5,325
Jaundice, infectious.....	3	1	1	1	6		185
Leprosy.....							
Lymphogranuloma venereum (lymphopatia venereum, lymphogranuloma inguinale).....	8	6	12	5	31		243
Malaria.....	7	2	4	2	15	7	360
Measles (rubeola).....	137	132	90	107	466	1,061	6,132
Meningitis, meningococci.....	6	9	3	6	24	53	527
Mumps (parotitis).....	178	240	208	134	760	1,942	13,996
Paratyphoid fever, A and B.....	1						74
Plague.....							
Pneumonia, infectious.....	44	36	42	26	148	358	2,300
Polioomyelitis, acute anterior.....	18	26	19	16	79	52	2,167
Psittacosis.....							6
Rabies, human.....	13	10	10	7	40	46	402
Rabies, animal.....	12	14	11	8	45		683
Relapsing fever.....							
Rheumatic fever.....							
Rocky Mountain spotted fever.....	141	160	116	91	508	912	7,363
Scarlet fever.....	11	3	10	5	29		149
Septic sore throat.....	332	398	362	394	1,486	1,893	24,316
Smallpox (variola).....							0
Syphilis.....	2	1	1		2		68
Tetanus.....	1						23
Trachoma.....							
Trichinosis.....	1						23
Tuberculosis, pulmonary.....	124	178	131	206	639	646	8,401
Tuberculosis, other forms.....	15	7	12	43	77	35	554
Tularemia.....				1	1		11
Typhoid fever.....		4		2	6	15	180
Typhus fever.....	2						5
Undulant fever (brucellosis).....	5	5	7	4	21		24
Whooping cough (pertussis).....	52	76	78	73	279	533	4,163
Yellow fever.....							
Totals.....					10,395		216,426

YEAR'S RAT TRAPPING ACTIVITIES

During 1946 the State Department of Public Health conducted rat trapping surveys in 78 cities and towns throughout California. Resurveys were made in 60 of these localities.

As a result of these activities, 25,121 rats were collected and examined. A total of 18,169 fleas and 1,271 lice were taken from these rats and sent to the laboratory for examination. Bubonic plague was not demonstrated in any of the rats or their parasites taken in urban surveys. Plague was demonstrated, however, in rats in a rural area of Ventura County.

